STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **10/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	**1101 GLEN OAKS ROAD** **SHELBYVILLE, TN 37160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 10/09/18 for all previous deficiencies cited on 08/20/18. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#1	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 08/20/2018. During this Life Safety Survey, Glen Oaks Health and Rehabilitation was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	K 000		
K 227 SS=D	Ramps and Other Exits CFR(s): NFPA 101 Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the discharge free of obstructions. The findings include: Observation on 08/20/2018 at 12:32 PM, revealed the ramp outside of the 200 B-Hall emergency egress doors had a rise greater than 6 inches	K 227	K 227 SS=D Ramps and Other Exits CFR(s): NFPA 101 The facility will maintain the discharge free of obstructions 1) The ramp outside of the 200 B-Hall emergency egress doors was fitted with handrails on 9/27/18 by facility maintenance staff. 2) Ramps outside of other emergency egress doors were audited for compliance on 8/20/18 by facility maintenance staff any issues found were	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cassandra L. Callahan | TITLE: Administrator | (X6) DATE: 9/21/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 9-21-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 227	Continued From page 1 (total rise was 16 inches) without hand rails or guards on both sides of the ramp. NFPA 101, 19.2.2.6.1 (2012 Edition) NFPA 101, 7.2.5.4.2 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 227	corrected then. 3) In-service was completed by Administrator on 8/20/18 with facility maintenance staff on maintaining exit ramps to NFPA 101 standards. The facility will monitor for compliance with audits completed by the facility maintenance 5 times a week for	
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain Aisle, Corridor or Ramp Width. The findings include: 1. Observation on 08/20/2018 between 12:33 PM and 1:30 PM, revealed push carts stored in the corridor in the following areas. a. outside of room B15 (med cart) b. outside of room 19 (linen cart) c. outside of room 4 (linen cart) d. outside of room A7 (linen cart) NFPA 101, 19.2.3.4 (2012 Edition) 2. Observation on 08/20/2018 at 12:42 PM,	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 227	Continued From page 1 (total rise was 16 inches) without hand rails or guards on both sides of the ramp. NFPA 101, 19.2.2.6.1 (2012 Edition) NFPA 101, 7.2.5.4.2 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 227	4 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks and 1 time a month for 1 month. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed	
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4 exceptions 1-5 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain Aisle, Corridor or Ramp Width. The findings include 1. Observation on 08/20/2018 between 12:33 PM and 1:30 PM revealed push carts stored in the corridor in the following areas: a. outside of room B15 (med cart) b. outside of room 19 (linen cart) c. outside of room 4 (linen cart) d. outside of room 47 (linen cart) (NFPA [illegible] 2012 Edition) 2. Observation on 08/20/2018 at 12:42 PM	K 232		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/20/2018

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K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain Aisle, Corridor or Ramp Width. The findings include: 1. Observation on 08/20/2018 between 12:33 PM and 1:30 PM, revealed push carts stored in the corridor in the following areas: a. outside of room B15 (med cart) b. outside of room 19 (linen cart) c. outside of room 4 (linen cart) d. outside of room A7 (linen cart) NFPA 101, 19.2.3.4 (2012 Edition) 2. Observation on 08/20/2018 at 12:42 PM,	K 232		

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GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

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K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4 exceptions 1-5 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by Based on observations, the facility failed to maintain Aisle, Corridor or Ramp Width. The findings include: 1. Observation on 08/20/2018 between 12:33 PM and 1:30 PM, revealed push carts stored in the corridor in the following areas: a. outside of room B15 (med cart) b. outside of room 19 (linen cart) c. outside of room 4 (linen cart) d. outside of room A7 (linen cart) (NFPA 101 - 2012 Edition) 2. Observation on 08/20/2018 at 12:42 PM	K 232	K 232 SS=E Aisle, Corridor or Ramp Width The facility will maintain aisle, corridor and ramp width. 1) a. The med cart outside of room B 15 was moved on 8/20/18 by facility staff b. The linen cart outside of room 19 was moved on 8/20/18 by facility staff c. The linen cart outside room 4 was moved on 8/20/18 by facility staff. d. The linen cart outside of room A7 was moved on 8/20/18 by facility staff. 2) The ramp outside of 200 B Hall emergency egress doors was widened to at least 48" on 9/19/18 by facility maintenance	

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K 232	Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 232	staff 3) a. Linen carts and med carts throughout the building were audited for compliance on 8/20/18 by facility maintenance staff to ensure they were moved. b. Ramps outside of emergency	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months: a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101, 7.9.3.1 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 232	Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 232	egress doors were audited by facility maintenance staff for proper width on 8/20/18 and any issues were addressed. 4) Facility maintenance staff was in-serviced on 8/20/18 by Administrator on keeping the path of egress clear and in-services for facility staff was	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting The findings include Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101 7.9.1.1 2012 Edition The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291		
K 726 SS=D	Maintenance, Inspection & Testing, Doors CFR(s): NFPA 101	K 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 232	Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 232	initiated by nurse educator on 8/22/18 on keeping the path of egress clear. Compliance will be monitored for during daily facility rounds by department head staff 5 times a week for 4 weeks, 2 times a week for 4 weeks and 1 time a week for 4 weeks and 1 time a month for 1	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting The findings include Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101 [illegible] 2012 Edition The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 232	Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 232	month. 5) 4. The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON,	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months: a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101, 7.9.3.1 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months: a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101, 7.9.3.1 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291	K 291 SS=D Emergency Lighting CFR(s): NFPA 101 The facility will maintain emergency lighting 1) Facility maintenance staff completed testing of emergency lighting on 8/20/18 and documented a test of the emergency lighting on 8/31/18 as scheduled thru TELS preventative maintenance programs. 2) Facility maintenance staff was in-serviced by the administrator on 8/20/18 on completing documentation of monthly	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 232	Continued From page 2 revealed the ramp outside of the emergency egress doors of 200 B-Hall was 42 inches wide at its narrowest width (minimum required width 48 inches). NFPA 101, 19.2.3.4* (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 232		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the emergency lighting. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the monthly emergency light test for the following months: a. 02/2017 through 06/2017 b. 03/2018 through 08/2018 NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101, 7.9.3.1 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 291	emergency lighting checks and entering it into the TELS system. Compliance will be monitored by the administrator by using the monthly TELS reports for 3 months. 3) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761	K 761 SS=D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the opening protective's. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the fire/smoke dampers within the last 4 years. NFPA 101, 8.2.2.4 (2012 Edition), NFPA 80, 19.4.1.1 (2010 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 761	Maintenance, Inspection & Testing – Doors CFR(s): NFPA 101 The facility will maintain the opening protectives. . 1) The fire/ smoke dampers were inspected by the Simplex Grinnell on 9/6/18. 2) Administrator in-serviced facility maintenance staff on 8/20/18 to ensure the required 4 year damper inspection is completed. 3) Facility maintenance staff will monitor for documentation of compliance monthly for 3 months through TELS reports. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON,	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		

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K 761	Continued From page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the opening protective's. The findings include: Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to provide documentation for the fire/smoke dampers within the last 4 years. NFPA 101, 8.2.2.4 (2012 Edition), NFPA 80, 19.4.1.1 (2010 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 761	Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918	K 918 SS=D Electrical Systems – Essential Electric Systems Maintenance and Testing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 4 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to maintain the Generator. The findings include:	K 918	CFR(s): NFPA 101 The facility will maintain the generator 1) On 8/21/18 Taylor Power Services came and reset the timing on the generator to run for 30 minutes under full load with a 15 minute cool down. 2) The Administrator in-serviced facility maintenance staff on 8/20/18 regarding the requirement to run the generator under full load for the full 30 minutes monthly. 3) Facility maintenance staff will document for compliance monthly 30 minute generator load test thru TELS reports and log inspection. The Administrator will monitor for compliance monthly for 3 months thru the TELS reporting system. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical	

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K 918	Continued From page 5 Document review on 08/20/2018 between 11:00 AM and 12:13 PM, revealed the facility failed to exercise the generator under a load for 30 minutes monthly. NFPA 101, 19.5.1.1 (2012 Edition), NFPA 101, 9.1.3.1 (2012 Edition), NFPA 110, 8.4.2 (2010 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 918	Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920	K 920 SS=D Electrical Equipment – Power Cords and Extension Cords CFR(s): NFPA 101 The facility will properly use power cords. 1) a. The power strip in room B 15 was removed 8/20/18 and replaced with the appropriate type. b. The power strip in room A 40 was removed 8/20/18 and replaced with the appropriate type. c. The power strip in room A 4 was removed on 8/20/18 and replaced with the appropriate	

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K 920	Continued From page 6 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to properly power cords. The findings include: Observations on 08/20/2018 between 12:32 PM and 1:28 PM, revealed power adapters not listed for the purpose in the following areas: a. RM B15 (1363A with personal equipment) b. RM A 40 (1363A with personal equipment) c. RM A 4 (1363A with personal equipment) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 920	type. 2) The facility maintenance staff audited resident rooms to ensure that power strips are being used for the appropriate purpose on 8/20/18 any issues identified were immediately corrected. 3) The Administrator in –serviced facility maintenance staff on 8/20/18 on the appropriate type and usage of power strips. Nurse educator initiated in-servicing facility staff on 8/22/18 regarding the appropriate type and usage of power strips. The facility will	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating	K 923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 920	Continued From page 6 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to properly power cords. The findings include: Observations on 08/20/2018 between 12:32 PM and 1:28 PM, revealed power adapters not listed for the purpose in the following areas: a. RM B15 (1363A with personal equipment) b. RM A 40 (1363A with personal equipment) c. RM A 4 (1363A with personal equipment) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 920	monitor for compliance during daily rounds by department head staff 5 days a week for 4 weeks 2 times a week for 4 weeks 1 time a week for 4 weeks and 1 time a month for 1 month. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist,	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr fire protection rating.	K 923		

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating	K 923	K 923 SS=D Gas Equipment – Cylinder and Container Storage CFR(s): NFPA 101 The facility will properly store oxygen cylinders. 1) Facility maintenance staff constructed an enclosure around the O2 cylinders on 08/30/18. 2) Administrator in-serviced	

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K 923	Continued From page 7 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review the facility failed to properly store oxygen cylinders. The findings include: Document review on 08/20/2018 at 12:13 AM, revealed oxygen bottles not secured from unauthoized access under the rear canopy by maintenance. NFPA 99, 11.6.2.3 (2012 Edition) The maintenance director was present for the findings which later were acknowledged by the administrator during the exit conference on 08/20/2018	K 923	facility maintenance staff on properly storing oxygen cylinders on 8/20/18. The Nurse Educator initiated an in-service on 8/30/18 for facility staff. The facility will monitor for compliance by doing weekly audits for 4 weeks and monthly audits for 3 months. 3) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18

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{E 000}	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 08/20/2018. During this Emergency Preparedness Survey, Glen Oaks Health and Rehabilitation Center was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients (2) include strategies for addressing emergency	E 006	E 006 SS=D Plan Based On All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) The facility will complete the risk assessment utilizing an all-hazards approach 1) The facility maintenance staff completed another risk assessment utilizing an all-hazards approach on 9/17/18. 2) The facility will review the assessment and adopt updated Disaster Preparedness Plan on 9/21/18 during the QAPI	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cassandra J. Callaha — TITLE: Administrator — (X6) DATE: 9/21/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	Continued From page 1 events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to complete the risk assessment utilizing an all-hazards approach per the requirements of Federal CFR §483.73. The finding included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, revealed the facility failed to maintain documentation of the facility based/community based risk assessment for the emergency preparedness program. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 006	meeting. 3) Administrator in-serviced facility maintenance staff on 8/20/18 on maintaining the complete all hazards facility risk assessment in the Emergency Preparedness Plan Binder. The facility will monitor for compliance by reviewing the disaster plan monthly during our QAPI meetings. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator,	
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a	E 015		

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E 006	Continued From page 1 events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to complete the risk assessment utilizing an all-hazards approach per the requirements of Federal CFR §483.73. The finding included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, revealed the facility failed to maintain documentation of the facility based/community based risk assessment for the emergency preparedness program. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 006	Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a	E 015	E 015 SS=D Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) The facility will include all policies and procedures for the subsistence needs of residents and staff in the emergency	

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	445234	A. BUILDING _____ B. WING _____	08/20/2018

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E 015	Continued From page 2 minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following. (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems.	E 015	preparedness program 1) The Administrator and other members of the QAPI committee developed a policy to address an alternate source of energy to maintain temperatures to protect resident health, emergency lighting, fire detection, extinguishing and alarm systems and sewage and waste disposal on 9/21/18. 2) The QAPI committee will adopt policy on 9/21/18 during QAPI Committee meeting. 3) Administrator in-serviced the facility maintenance staff on 8/20/18 on maintaining the policy that addresses the alternate energy source in the Emergency Preparedness Plan Binder. The facility will monitor for compliance by reviewing the disaster plan monthly during our QAPI meetings. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed	

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E 015	Continued From page 3 (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record reviews, the facility failed to include all policies and procedures for the subsistence needs of residents and staff in the emergency preparedness program. The findings included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, the facility failed to provide policies and procedures for alternate sources of energy to maintain the following: a. Temperatures to protect resident health. b. Emergency lighting c. Fire detection, extinguishing, and alarm systems d. Sewage and waste disposal This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 015	for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
E 020 SS=D	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes	E 020	E 020 SS=D Policies for Evac. And Primary/ ALT Communication CFR(s): 483.73(b)(3) The facility will provide evacuation policies and procedures based on the emergency plan. 1) The Administrator and other members of the QAPI	

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E 020	Continued From page 4 consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs, staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to provide evacuation policies and procedures based on the emergency plan. CFR §483.73 (b) (3)	E 020	committee developed a policy on 9/21/18 to address specific staff responsibilities and the needs of the evacuees during an evacuation. 2) The QAPI committee will adopt policy on 9/21/18 during QAPI Committee meeting. 3) The Administrator in-serviced the facility staff on 9/21/18 on having a policy that addresses the specific responsibilities of staff and the needs of the evacuees during an evacuation. The facility will monitor for compliance by reviewing the disaster plan monthly during our QAPI meetings. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions,	

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E 020	Continued From page 5 The findings included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, the facility could not provide evacuation polices and procedures that included specific staff responsibilities and the needs of the evacuees during an evacuation. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 020	Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18
E 032 SS=D	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies in the	E 032	E 032 SS=D Primary/ Alternate Means for Communication CFR(s): 483.73(c)(3) The facility will include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, Tribal, regional and local emergency management agencies in the emergency preparedness program. 1) On 9/21/18 the Administrator and other members of the QAPI committee developed a policy for primary and alternate means of communicating with facility staff during an emergency on 9/21/18.	

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E 032	Continued From page 6 emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 08/20/2018 between 1:55 PM and 2:40 PM, revealed the facility had no record of polices and procedures for primary and alternate means for communicating with facility staff during an emergency. This finding was verified by the administrator during the review of the facility's emergency preparedness program.	E 032	2) The QAPI committee will adopt policy on 9/21/18 during QAPI Committee meeting. 3) Administrator in-serviced the facility staff on 9/21/18 on the policy that addresses a primary and alternate means of communicating with facility staff during an emergency. The facility will monitor for compliance by reviewing the disaster plan monthly during our QAPI meetings. 4) The Administrator will report findings of the audits monthly to the QAPI committee for follow up and recommendations as needed for 3 months. The QAPI committee consist of Medical Director, Administrator, DON, Unit Managers, Wound Nurse/ Infection Preventionist, Resident Financial Coordinator, Human Resources, Admissions, Medical Records, Social Services, Plant Operations Manager, Activities and Dietary.	9/27/18